PRINTED: 01/09/2012 FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE (	CONSTRUCTION	(X3) DATE	SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED			
		155298		A. BUILDING			12/13/2011		
			B. WIN		TADDRESS SITY STATE TIP CODE				
NAME OF I	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP CODE						
CAMBRI	DGF MANOR NUR	SING & REHABILITATION CEN	ΓFR	8530 TOWNSHIP LINE RD ER INDIANAPOLIS, IN46260					
			· - · ·				(37.5)		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG		ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE		
	REGULATORT OR	LESC IDENTIFITING INFORMATION)		TAG			DATE		
F0000									
	This visit was fo	r the investigation of	FO	000					
		_	10	.000					
	complaint number IN00100584.								
	Complaint INOO	100584 substantiated.							
	•	iciencies related to the							
	anegations are c	ited at F225 and F226.							
		1 7 0 0 12 12							
	1	cember 7, 8, 9, 12, 13,							
	2011								
	Facility number:								
	Provider number								
	AIM number: 1	00267690							
	Survey team:								
	Charles Stevenso	on RN							
	Census bed type								
	SNF/ NF: 88								
	Total: 88								
	Census payor typ	pe:							
	Medicare: 11	L							
	Medicaid: 64								
	Other: 13								
	Total: 88								
	101.00								
	Sample: 3								
	Trian 1 C · ·	and Grade de C. T.							
		es reflect state findings							
	cited in accordar	nce with 410 IAC 16.2.							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VOXJ11

Facility ID:

000195

If continuation sheet

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155298		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/13/2011	
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
CAMBRII	DGE MANOR NUR	SING & REHABILITATION CENTE		OWNSHIP LINE RD APOLIS, IN46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Quality review c Cathy Emswiller	ompleted 12/15/11 RN			

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155298		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE COMPL 12/13/2	ETED		
	PROVIDER OR SUPPLIEF	SING & REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE  8530 TOWNSHIP LINE RD  INDIANAPOLIS, IN46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0225 SS=D	The facility must re have been found or mistreating resistance had a finding nurse aide registry mistreatment of resistance and facility must be service as a nurse the State nurse aide authorities.  The facility must be violations involving abuse, including in and misappropriate reported immediate the facility and to with State law three (including to the Sagency).  The facility must be agency).  The facility must be all including to the Sagency of the investigation is the investigation is the reported to the addrepresentative and accordance with Sate survey and working days of the side of the side of the sagency	dents by a court of law; or gentered into the State y concerning abuse, neglect, esidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing  ensure that all alleged g mistreatment, neglect, or nijuries of unknown source tion of resident property are tely to the administrator of other officials in accordance ough established procedures state survey and certification  have evidence that all are thoroughly investigated, further potential abuse while in progress.  Investigations must be ministrator or his designated d to other officials in State law (including to the certification agency) within 5 he incident, and if the alleged d appropriate corrective						
	Based on record review and interview, the facility failed to protect residents from potential verbal abuse for residents involved in a group activity and failed to protect a resident (Resident B) after an		F0	225	Element #1: It is the policy of theis facility to see that any allegation of abuse or any a abuse is thoroughly investig immediately reported to the administrator and reported to	ctual ated,	01/12/2012	

000195

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155298		A. BUI	LDING	NSTRUCTION  00	(X3) DATE COMPL 12/13/2	ETED	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIER	t			OWNSHIP LINE RD		
		SING & REHABILITATION CENT	ER	INDIAN	APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1	ually inappropriate			state agency (ISDH). Furthe any residents involved is to b		
	1	cility visitor by not					
	thoroughly investigating and reporting to				protected immediately from a further abuse or further poter	•	
	the State Agency	as required by State law			abuse. Additionally, all threa		
	and facility polic	ey for 1 of 3 residents			are to be immediately remov		
	reviewed for inv	estigation and reporting			from the facility. This include	es	
	of allegations of abuse. (Resident B)  Findings include:				any person who may be suspected of alleged abuse. residents in group settings as		
					as residents in group settings as as resident B are protected a kept safe at all times. Plus, a	ınd	
	The record of De	ogidant D was reviewed			residents involved in any inci		
	The record of Resident B was reviewed on 12/09/11 at 10:00 a.m.				of abuse or alleged abuse wi		
					have that incident thorougly a completely investigated and	and	
	Diagnoses includ	ded, but were not limited			reported to all appropriate pa		
	_	ease, seizure disorder,		as stated in the facility polic per regulation set forth by the			
	· ·	nic leukocytosis, and			state and federal agencies.	9	
	anxiety.	me realisely tools, and			Activity aide #1 has been		
	unxiety.				counseled and educated as t	to	
	During on interv	iew on 12/12/11 at 9:45			their parameter as far as		
	a.m. with the 3rd				acceptable language and		
					behaviors to be used with		
	_	nt Director of Nursing			residents. Element #2: All residents have the potential to	n he	
	` ′	icated that on Sunday			affected by this finding. The	0 00	
		eived a phone call from a			administrator interviewed the	:	
		floor indicating an			resident s in the afore mention		
		een made that a male			"group" that had been led by		
	visitor had been	in a female resident's			activity aide #1 to see if any		
	room (Resident I	B) while the resident was			residents had been offended None had. Resident B was	•	
	partially uncloth	ed. The ADON indicated			reminded to keep her door sl	hut	
	that she then can	ne to the facility,			when she is not completely	· -	
	investigated the incident, and prepared a report of her findings. The ADON indicated she placed her report in a sealed envelope and put it in the mail box of the				dressed as passersby could		
					glance in her room and see h		
					(This behavior is and was on		
					careplan). Going forward, al incidents of abuse or potential		
		ing (DON). The ADON			abuse will be immediately	ai.	
	Director of Nurs	ing (DON). The ADON					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL	
		155298	A. BUI B. WIN	LDING IG		12/13/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER	<b>{</b>		1	DWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENTI	ΞR	INDIAN	APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	reported to the adminsitrator	and	DATE
	also indicated that on 10/24/11 she was asked by the Director of Operations (DO)						
	1	* '			the policy and procedure as stated prior will be followed a	ıs far	
		port of the incident from			as safety, assessment,		
	_	ve it to her (the DO). The			investigation and reporting to		
	ADON indicated	i she did this.			proper parties will be followe Element #3: At an all staff	u.	
	D	' 'd d DON			inservice held 1/10/2012 the		
		iew with the DON on			policy and procedure for abu	se	
		0 a.m. the DON indicated			will be covered including: 1.		
		l a sealed envelope from			Abuse Policy 2. Types of ab 3. Step by step action to be	use	
	the ADON from				taken if abuse is suspected.	4.	
	10/24/11. She indicated that before she				Questiions/answers/discussions	on	
	could read it, the ADON retrieved it from				Any staff who fail to comply v		
	•	at she had been instructed			the points of the inservice will further disciplined as appropriately		
	1	was to have copies of			up to and including termination		
	her investigation	i.		Element #4: At the monthly QA	QΑ		
					meetings, any reports of abu		
		mented dated 10/23/11			alleged abuse will be reviewed		
		epared by the ADON and			be certain all proper protocol were followed including, but		
		report of the incident of			limited to: 1. Providing		
		ng Resident B included,			immediate safety for resident	ts 2.	
	but was not limit	ted to:			Removing threat/assessing		
					resident 3. Reporting to the adminisrator 4. Complete		
		ived a phone call			investigation/interviews 5. All		
		on the 3rd floor that there			proper reporting to all approp		
	-	n the building and that he			parties. Any concerns will be		
		ent's room that wasn't			immediately addressed by th administrator.	е	
		y Aide #1) brought the			administrator.		
	` ′	to the nurses station and					
		nd told the res to tell					
		pened and res stated 'I					
	told him to get the h out of my room and he didn't and then I told him again.'						
	` .	Aide #1) stated he checked					
	and that the prea	cher wasn't even					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155298	B. WIN			12/13/2	011
C. C. C. C.				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIE	R		8530 TO	OWNSHIP LINE RD		
		SING & REHABILITATION CENT	ER		APOLIS, IN46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n the building until 6:30					
	p.m. The nurse also reported that the aides from the second floor were here sayingthat (Activity Aide #1) was going						
	all over the bldg	(building) telling people					
	and now it was g	going to be reported to the					
	state.						
	(CNA #4) phone	ed this writer and stated					
		r was in the hallshe					
		who the resident wasshe					
	stated it was (Resident B)then she went to the doorand noticed she (Resident B)						
	had only a shirt	` '					
	liad only a silit	OII					
	A "Notice of Dis	sciplinary Action: dated					
		gned as completed by					
	_						
		ctivity Aide #1 included,					
	but was not limi	tea to:					
	"Employee's Na	me: (Activity Aide #1)					
	Demonto 1 A A CA	at to Attack to the					
	`	activity Aide) brought					
	1	(nursing) station et (and)					
	_	Man in her rm (room) et					
	_	get the h out X2 (twice).					
		1) responded with 'I					
	checked the sche	edule he's not supposed to					
	be in her till 6:30(Activity Aide #1) then to 2nd floor stating it would be a reportable to state"						
	During an interv	view with the					
	_	n 12/07/11 at 3:00 p.m. he					
					<u> </u>		<u> </u>

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	LTIPLE CO	NSTRUCTION		(X3) DATE		
AND PLAN	OF CORRECTION		EK:	A. BUIL	DING	00		COMPL	
		155298		B. WINC	_			12/13/2	UII
NAME OF P	ROVIDER OR SUPPLIER					ADDRESS, CITY, STA			
			TION CENT	_		OWNSHIP LINE			
		SING & REHABILITA		ĸ	INDIAN	APOLIS, IN4626	OU .		
(X4) ID		TATEMENT OF DEFICIENC			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	CY MUST BE PERCEDED I LSC IDENTIFYING INFOR		]	PREFIX	CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	ΓE	COMPLETION
TAG					TAG	DEF	ionato i j		DATE
		y Aide #1 "walks a	iine						
		issing inappropriate							
		os including female							
	residents and that he sometimes has to								
	"reign him in." He also indicated that								
	"sometime recently" (date uncertain) that								
	•	orted to him what sh	e						
		incident of resident							
		e indicated Activity							
	_	n activity group in t							
	_	with approximately							
		dance, "mostly fem							
		pics discussed, inclu	•						
		nd related activities,							
	have been inappr	ropriate and potentia	ally						
	distressing to sor	me residents present	- ••						
	LPN #5 was inte	rviewed on 12/07/1	1 at						
	3:20 p.m. She inc	dicated that she had	been						
	working at the 31	rd floor nurse's stati	on						
	and heard Activi	ty Aide #1 leading a	ı						
	group discussion	, and that the topics	of						
	discussion were	-							
		cluding homosexual	lity						
		ties. She indicated s	-						
		nat some topics of							
		nave been offensive	or						
	_	me residents presen							
	_	ve had fear or anxie							
		indicated she had	,						
	presented her concerns directly to the								
	Administrator on the day it occurred but								
	that she had not been advised of any								
		igation or intervention							
FORM CREE							TO		
FORM CMS-2	567(02-99) Previous Version	ons Obsolete	Event ID: VC	XJ11	Facility I	D: 000195	If continuation sh	neet Par	ge 7 of 15

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155298	B. WIN	G		12/13/2	011
NAME OF I	PROVIDER OR SUPPLIEI	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENT	=R	INDIAN	APOLIS, IN46260		
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PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	A Constitute Physical Physical Constitute Physical Constitute Physical Constitute Phys	on CDinainlinen Antion!					
	1	ce of Disciplinary Action"					
	dated 10/07/11 for Activity Aide #1 indicated "Inappropriate material, shared with others. Questionable topic						
		•					
	covered in group	o discussions.					
	During an interv	riew with the					
	_	n 12/12/11 at 2:40 p.m. he					
		e above incidents had					
		him as documented. He					
	-	e consideration to each					
	_	cided the allegations did					
	•	ng to the State Agency.					
	_	d he had investigated the					
		d no documentation of					
	-	n, including but not					
		fying potentially affected					
		iewing residents to					
		ivity Aide #1 had a					
		abuse or other concerns,					
	_	staff members to establish					
	_	ttern of verbally abusive					
	_	ivity Aide #1. He also					
	1	e incident of 10/23/11					
		ent B had not been					
	_	State Agency and that he					
	-						
	had not done a formal, documented investigation to determine if there was any potential risk to residents based on the						
	allegations of the						
	3.1-28(c)						
	l				<u> </u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298			LDING	00	(X3) DATE : COMPL 12/13/2	ETED	
	PROVIDER OR SUPPLIER	SING & REHABILITATION CENTE	R	8530 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0226 SS=D	written policies and mistreatment, neg and misappropriat Based on record facility failed to potential verbal a involved in a groprotect a resident allegation of sexubehavior by a fact thoroughly invest the State Agency and facility policing reviewed for involved in a groprotect a resident allegation of sexubehavior by a fact thoroughly invest the State Agency and facility policing reviewed for involved allegations of Findings include  1. The record of reviewed on 12/0 Diagnoses include to, sickle cell dishepatitis C, chromanxiety.  During an interview.	Resident B was 19/11 at 10:00 a.m. led, but were not limited ease, seizure disorder, nic leukocytosis, and lew on 12/12/11 at 9:45	F0	226	Element #1: It is the policy of theis facility to see that any allegation of abuse or any ac abuse is thoroughly investigatimmediately reported to the administrator and reported to state agency (ISDH). Further residents involved is to be protected immediately from a further abuse or further poter abuse. Additionally, all threat to be immediately removed fit the facility. This includes any person who may be suspected alleged abuse. All residents in group settings as well as residents involved in any incident of abour alleged abuse will have the incident thorougly and compliance investigated and reported to appropriate parties as stated the facility policy and per regulation set forth by the state and federal agencies. Activity aide #1 has been counseled educated as to their parameter far as acceptable language as behaviors to be used with residents. Element #2: All residents have the potential that affected by this finding. The	etual ated, o the cr, any ontial as are rom ed of n ident e at etely all in ate y and er as and	01/12/2012

000195

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL		
11112 12111	or condition.	155298		LDING		12/13/2	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF	PROVIDER OR SUPPLIER	8	STREET ADDRESS, CITY, STATE, ZIP CODE  8530 TOWNSHIP LINE RD				
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CEN					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	<u> </u>		DATE
	` ′	icated that on Sunday			administrator interviewed the resident s in the afore mention		
		eived a phone call from a			"group" that had been led by		
		floor indicating an			activity aide #1 to see if any		
	_	een made that a male			residents had been offended	d.	
		in a female resident's			None had. Resident B was	h4	
	room (Resident)	B) while the resident was			reminded to keep her door s when she is not completely	nut	
		ed. The ADON indicated			dressed as passersby could		
	that she then can	ne to the facility,			glance in her room and see		
	investigated the	incident, and prepared a			(This behavior is and was or		
	report of her find	lings. The ADON			careplan). Going forward, all		
	indicated she pla	iced her report in a sealed			incidents of abuse or potenti abuse will be immediately	aı	
	envelope and pu	t it in the mail box of the			reported to the adminsitrator	and	
	Director of Nurs	ing (DON). The ADON			the policy and procedure as		
		at on 10/24/11 she was			stated prior will be followed a	as far	
	asked by the Dir	ector of Operations (DO)			as safety, assessment,		
	_	port of the incident from			investigation and reporting to proper parties will be follower		
		ve it to her (the DO). The			Element #3: At an all staff	.u.	
	ADON indicated	, ,			inservice held 1/10/2012 the		
	71DON indicated	i she did this.			policy and procedure for abu		
	During an interv	iew with the DON on			will be covered including: 1.		
	_	0 a.m. the DON indicated			Abuse Policy 2. Types of ab Step by step action to be tak		
					abuse is suspected. 4.	CITII	
		l a sealed envelope from			Questiions/answers/discussi	ion	
	the ADON from				Any staff who fail to comply		
		dicated that before she			the points of the inservice wi		
		ADON retrieved it from			further disciplined as approp		
		at she had been instructed			up to and including terminati Element #4: At the monthly (		
	_	was to have copies of			meetings, any reports of abu		
	her investigation	l.			alleged abuse will be review	ed to	
					be certain all proper protoco		
	An untitled documented dated 10/23/11 and signed as prepared by the ADON and identified as her report of the incident of				were followed including, but		
					limited to: 1. Providing imme safety for residents 2. Remo		
					threat/assessing resident 3.		
	10/23/11 involvi	ng Resident B included,			Reporting to the adminisrato	r 4.	
	but was not limit	ted to:			Complete investigation/inter	views	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155298			LDING	NSTRUCTION  00	(X3) DATE COMPL 12/13/2	ETED		
	PROVIDER OR SUPPLIER	SING & REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE  8530 TOWNSHIP LINE RD  INDIANAPOLIS, IN46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	was a preacher in went into a resid dressed. (Activity res (Resident B)seemed mad ar nurses what happy told him to get the and he didn't and Then (Activity A and that the preaches supposed to be in p.m. The nurse a from the second sayingthat (Activate all over the bldg and now it was gestate.  (CNA #4) phone that the preacher asked the nurse we stated it was (Reto the doorand had only a shirt of A "Notice of Dis 10/23/11 and sig ADON #3 for Activity and the preacher asked the nurse we stated it was (Reto the doorand had only a shirt of the doorand had o	on the 3rd floor that there in the building and that he ent's room that wasn't by Aide #1) brought the to the nurses station and and told the res to tell bened and res stated 'I he h out of my room at then I told him again.' wide #1) stated he checked be cher wasn't even in the building until 6:30 also reported that the aides floor were here tivity Aide #1) was going (building) telling people going to be reported to the wasn't even the hallshe who the resident wasshe sident B)then she went noticed she (Resident B) on"			5. All proper reporting to all appropriate parties. Any concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be immediately addressed by the administration of the concerns will be administration of the conc			

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155298			LDING	NSTRUCTION  00		(X3) DATE ( COMPL 12/13/2	ETED	
	PROVIDER OR SUPPLIEI	R SING & REHABILITATION CE	<u> </u>	STREET A	DDRESS, CITY, STA DWNSHIP LINE APOLIS, IN4626	RD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION TE ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	(X5) COMPLETION DATE
	resident to nrsg (had her report 'N she told him to g (Activity Aide # checked the sche be in her till 6:30 to 2nd floor stati reportable to stati reportable about discumaterial in group residents and that "reign him in." I "sometime recer LPN #5 had repoblieved was an verbal abuse. Sh #1 was leading a 3rd floor dining residents in atternand that some to homosexuality a have been inapp distressing to so LPN #5 was interesting to so LPN #5 was interesting at the 3 working at the 3							
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event ID:	VOXJ11	Facility I	D: 000195	If continuation sh	eet Pac	ge 12 of 15

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUII	DING	00		COMPLETED	
		155298		B. WIN				12/13/2011	
MAME OF BROWINED OR CURRILIED					_	DDRESS, CITY, STA	ATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIER					8530 TC	WNSHIP LINE	RD		
CAMBRIDGE MANOR NURSING & REHABILITATION CENT					INDIAN	APOLIS, IN4626	60		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				ID	PROVIDER'S P	PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	CROSS-REFERENCED TO THE APPROPRI			COMPLETION	
TAG				TAG	DEF	FICIENCY)	IENCY) I		
	group discussion, and that the topics of								
	discussion were	•	4.						
		cluding homoses	-						
	and sexual activities. She indicated she								
		hat some topics of							
		have been offens							
	1	ome residents pre							
		ive had fear or an	•						
		o indicated she ha							
	^	oncerns directly to							
	Administrator on the day it occurred but that she had not been advised of any								
	follow up investigation or interventions.								
	A facility "Notice of Disciplinary Action" dated 10/07/11 for Activity Aide #1 indicated "Inappropriate material,								
	shared with other	ers. Questionable	topic						
	covered in group	covered in group discussions."							
	During an interview with the								
	Administrator on 12/12/11 at 2:40 p.m. he indicated that the above incidents had been reported to him as documented. He								
	indicated he gave consideration to each incident, and decided the allegations did not merit reporting to the State Agency.								
	He also indicated he had investigated the incidents, but had no documentation of any investigation, including but not limited to identifying potentially affected residents, interviewing residents to determine if Activity Aide #1 had a history of verbal abuse or other concerns,								
	_	staff members to							
FORM CMC	-					D 002/27	IC	, -	10.6:-
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete	Event ID:	VOXJ11	Facility I	D: <b>000195</b>	If continuation sh	neet Par	ge 13 of 15

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	ľ ′	3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
155298		155298	B. WIN			12/13/2011		
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	₹		8530 TC	OWNSHIP LINE RD			
CAMBRIDGE MANOR NURSING & REHABILITATION CENT				INDIAN	APOLIS, IN46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	if there was a pattern of verbally abusive behavior by Activity Aide #1. He also indicated that the incident of 10/23/11 involving Resident B had not been reported to the State Agency and that he							
	had not done a fe	ormal, documented						
	investigation to determine if there was any potential risk to residents based on the							
	allegations of the							
	2. An undated facility document titled "Abuse Protection and Response Policy" received from the Administrator on							
	12/07/11 at 3:00 p.m. and indicated to be the facility's current policy included, but was not limited to:  "Policy: The center's administrator is							
	responsible for assuring that patient							
	safety, including freedom from risk of abuse, holds the highest priorityReporting and Response Issues: Procedure: Any allegation of abuse will							
	be reported immediately to the supervisor and administrator. Any investigation that substantiates abuse or neglect al alleged							
	abuse or neglect findings will be reported immediately to the Administrator his/her designated representative and to other officials in accordance with State Law							
	within 24 hours of the event.							
	2.1.20()							
	3.1-28(a)							

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00				(X3) DATE SURVEY COMPLETED			
155298			B. WING				12/13/2011			
NAME OF B	NOTABLE OF CLIBBLIES				TREET ADI	DRESS, CITY, STATI	E, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER		8530 TOWNSHIP LINE RD							
CAMBRIDGE MANOR NURSING & REHABILITATION CENTE										
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES				D	PROVIDER'S PLAI	N OF CORRECTION	F CORRECTION (X5)		
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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VOXJ11 Facility ID: 000195 If continuation sheet Page 15 of 15						ge 15 of 15				